This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☑ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

9/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

☐ Specific Injury

Case Number 1 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420

Body Part 2: 100

Body Part 3:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☑ RSU

Companion Cases

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: RSU

Document Type: DWC - AD FORMS

Document Title: DWC-AD 10120 REQUEST FOR REIMBURSEMENT OF ACCOMMODATION EXPENSES

Date of document following Document Separator Sheet

Document Date: _____ MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name.
If you are the employer, "Author" is employer

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date: _____ MM/DD/YYYY

Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005

Name of Employer: Address of Employer:

Phone Number: Name of Injured Employee:

WCAB number (if applicable): Claim Number

Job Title (at time of injury):

Job Duties (attach job description if available):

Date of Injury:

Reimbursement is requested for expenses to accommodate a:

_____ temporarily disabled employee ($1250 maximum)

_____ permanently disabled employee ($2500 maximum)

Employee's work restrictions and accommodation required (attach treating physician's, QME or AME report):

Itemized list of costs for which reimbursement is requested (attach all receipts):

1. Modification to worksite (list all work done and total cost) Cost

2. Equipment, furniture and/or tools (list each item and cost) Cost

3. Any other accommodation expenses: Cost

(Attach additional sheets if necessary)

Total Costs:

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

Signature of employer or employer's representative Date

MANDATORY FORMAT
STATE OF CALIFORNIA
8 CCR Section 10005

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: RSU

Document Type: SUPPORTING DOCUMENTS

Document Title: STD FORM 204 - PAYEE DATA RECORD

Document Date: _____ MM/DD/YYYY

Date of document following Document Separator Sheet

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name.
If you are the employer, "Author" is employer

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date: _____ MM/DD/YYYY

DWC-CA form 10232.2

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 6-2003)

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.

NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)

E-MAIL ADDRESS

MAILING ADDRESS

BUSINESS ADDRESS

CITY, STATE, ZIP CODE

CITY, STATE, ZIP CODE

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): ☐☐-☐☐☐☐☐☐☐

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:

- ☐ **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ **LEGAL** (e.g., attorney services)
- ☐ **EXEMPT** (nonprofit)
- ☐ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:** ☐☐☐-☐☐-☐☐☐☐

(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4

PAYEE RESIDENCY STATUS

☐ California resident - Qualified to do business in California or maintains a permanent place of business in California.

☐ California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.

- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)

TITLE

SIGNATURE

DATE

TELEPHONE

( )

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ **Fax:** (___) _____

E-mail Address: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: RSU

Document Type: SUPPORTING DOCUMENTS

Document Title: MEDICAL REPORT

Document Date: 02/05/2008
MM/DD/YYYY

Author: JOHN A SMITH MD

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

DR. JOHN A. SMITH MEDICAL REPORT
Containing work restrictions being accommodated

REPORT DATED February 5, 2008

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: RSU

Document Type: SUPPORTING DOCUMENTS

Document Title: JOB DESCRIPTION

Document Date: 06/05/2008
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name.
If you are the employer, "Author" is employer

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

OTHER SUPPORTING DOCUMENTS

DATED June 5, 2008

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: RSU

Document Type: SUPPORTING DOCUMENTS

Document Title: EQUIPMENT AND MODIFICATION INVOICES

Document Date: 04/05/2008
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name.
If you are the employer, "Author" is employer

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

ALL RECEIPTS FOR ACCOMODATION EXPENSES

DATED April 5, 2008